Schedule of Benefits (Face Sheet)

This is a summary of your benefits. See your Summary Plan Description for more detailed information.

Plan Name: **City of Mattoon Group Health Benefits Plan**
Effective Date: **January 1, 2004**
Medical Package: **City of Mattoon PPO/ASO**
Rx Package: **See Applicable Rider**

BASICS	Maximums, Deductibles, and Limitations	
Annual Medical Deductible	In-Network	Out-of-Network
Individual	$300	$500
Family	$600	$1,000
	Deductibles must be met first. The family maximum includes covered expenses which are used to satisfy deductibles for all family members combined. Well baby and well child care, routine immunizations, routine examinations (including gynecological examinations), accident benefit and second surgical opinions are not included on your deductible. Any covered medical expenses incurred and applied toward the individual and family deductible amount during the last three (3) months of the year (Oct, Nov, Dec) are applied to the individual and family deductible amount for both present and the following calendar years. Out-of-pocket reimbursement of 100% does not carry over.	
Out-of-Pocket Maximum	In-Network	Out-of-Network
Individual	$1,000	$2,000
Family	$2,000	$4,000
	The family out-of-pocket maximum includes out-of-pocket maximums for all family members combined. In- and Out-of-Network expenses will be applied equally toward the satisfaction of both the In- and Out-of-Network out-of-pocket maximums. Does not include contract year deductibles, prescription drug co-payments, charges in excess of benefit maximums or U&C fees, and non-compliance penalties.	
Lifetime Maximum	$2,000,000	
Prior Authorization Requirements	Certain services (including all surgeries and hospital admissions) require prior authorization. Failure to prior authorize will result i a fifty percent (50%) reduction in benefits.	
Maximum Allowable Charge	Except for emergency services, charges by out-of-network providers in excess of maximum allowable charge will not be covered.	
Benefit Maximums	Any maximums which are stated in dollar amounts, number of days or number of treatments and which limit either the maximum benefits payable or the maximum allowable covered expenses are the combined maximums under both the in- and out-of-network level of benefits.	
Annual Pharmacy Deductible per Individual	N/A	
Annual Pharmacy Maximum	N/A	

IN THE HOSPITAL	Description	You Pay In-Network	You Pay Out-of-Network
Hospital Care	Hospital services are covered when prior authorized. The Plan should be notified of emergency admissions within 48 hours.	10% coinsurance per admission	30% coinsurance per admission
Number of Days of Inpatient Care	Unlimited number of medical/surgical stays, subject to medical necessity.	See Hospital Care	See Hospital Care
Room and Board	Coverage is provided for semi-private room and board or specialty unit, when medically necessary.	See Hospital Care	See Hospital Care
Medications	Coverage is included under Hospital Care. Take-home drugs dispensed to you prior to your release are not covered. You may have benefits as outlined in a prescription drug rider, if applicable.	See Hospital Care	See Hospital Care
Other Miscellaneous Charges	Coverage is included under Hospital Care. Personal comfort or convenience items are not covered.	See Hospital Care	See Hospital Care
In-Patient Physician Services	Includes radiologist, pathologist, anesthesiologist, emergency room physician, among others. Captive services will be paid at in-network benefit level.	20%	30%
Surgical Physician Services		10%	30%
Second Surgical Opinion	Requires notification to Plan.	0%	0%
Procedures, Diagnostics, and Therapeutics	Includes x-ray examinations, laboratory tests, therapeutics and pathology services.	20%	

IN THE DOCTOR'S OFFICE	Description	You Pay In-Network	You Pay Out-of-Network
Primary Care Physician (PCP)	Evaluation and Management Services; includes nurse practitioners and physician assistants.	10%	30%
Specialist Other Than Listed in Medical Services	Evaluation and Management Services; includes nurse practitioners and physician assistants.	10%	30%
Procedures, Diagnostics and Therapeutics	Includes x-ray examinations, laboratory tests, therapeutic injections, therapeutics and pathology services.	20%	
Well Baby and Well Child Care	Covered when administered by in-network providers.	0%	Not Covered
Adult/Child Immunizations	Covered when administered by in-network providers.	0%	Not Covered
Routine Examinations	No coverage out-of-network except for mammograms/pap smears where you pay a 20% coinsurance.	0%	Not Covered
Allergy Treatment and Testing	Covered. See Summary Plan Description for further information.	See In The Doctor's Office: Procedures, Diagnostics, and Therapeutic Services.	
Wellness Care	According to published preventive care guidelines.	See applicable office visit, hospital, and outpatient services sections for copayment or coinsurance.	

MEDICAL SERVICES	Description		You Pay In-Network	You Pay Out-of-Network
Outpatient Surgery	Except for minor surgeries or diagnostic procedures performed in doctor's office, requires prior authorization		10%	30%
Outpatient Observation Stays	Observation services are covered up to 24 hours when prior authorized.		10%	30%
Outpatient Diagnostics and Therapeutics			20%	
Maternity Care Hospital Care	Coverage for 48 hours of inpatient care following a vaginal delivery or 96 hours of inpatient care following a delivery by cesarean section. Inpatient care beyond these timeframes requires prior authorization.		10%	30%
Physician Care	Routine prenatal, delivery, and postnatal care.		10%	30%
	Care provided by other physicians and specialists may result in assessment of additional copayments/coinsurance.		See applicable office visit, hospital, and outpatient services sections for copayment or coinsurance.	
Infertility Services	Infertility means the inability to conceive after one year of unprotected sexual intercourse or the inability to sustain a successful pregnancy.		Not Covered.	
Mental Health		Covered per contract year:		
Inpatient	When prior authorized.	60 Days	20%	
Outpatient	Benefit maximum combined w/ substance abuse care	30 Visits	20%	
Substance Abuse		Covered per contract year:		
Inpatient	When prior authorized.	30 Days	20%	
Outpatient	Benefit maximum combined w/ mental health care	30 Visits	20%	
Rehabilitation Services Inpatient and Outpatient	Includes physical, occupational, speech and cardiac rehabilitation therapies. Benefit maximum of 60 days per illness or injury.		10%	30%
Anesthesiologist Services	Professional fees. Captive services paid at in-network benefit level.		20%	30%
Radiologist and Radiology Services	Professional and technical fees. Captive services paid at in-network benefit level.		20%	30%
Pathologist/Laboratory Services	Professional and technical fees. Captive services paid at in-network benefit level.		20%	30%

EMERGENCY SERVICES	Description	You Pay	
Emergency Room Medical Services	$50 co-payment per ER visit up to maximum of $300. Remaining eligible expenses payable at applicable coinsurance rates.	10%	30%
Emergency Room Accident Services		10%	10%

Emergency Room Physician Services	Professional fees.	20%
Emergency Transportation by Ambulance	Covered when medically necessary for land or air transport within continental USA/Canada.	20%
Emergency Post-Stabilization Services	Covered when medically necessary.	See Hospital Care for applicable coinsurance or co-payment.

OTHER MEDICAL SERVICES	Description	You Pay In-Network	You Pay Out-of-Network
Durable Medical Equipment	Covereage for medically necessary, standard model equipment.	20%	
Prosthetic Devices	Coverage for medically necessary, standard model prostheses, prosthetic appliances and implants.	20%	
Hospice	Covered (up to six months).	10%	30%
Home Health Care	100 visit limit per contract year.	10%	30%
Private Duty Nursing	Limited to $1,000 per month	10%	30%
Vision Care	Not covered. Coverage for vision screening and refractive services may be covered by a separate vision plan, if applicable.	Not applicable	Not applicable
Dental Services	Not covered. Coverage for dental services may be covered by a separate dental plan, if applicable.	Not applicable	Not applicable
Skilled Nursing Facilities	Short-term, non-custodial care in a skilled nursing facility is covered when medically necessary for convalescence from an illness or injury.	10%	30%
Chiropractic Services	Limited to 20 visits per contract year not to exceed $500.	20%	
Organ Transplants	Covered when medically necessary and when prior authorized, performed at an approved Coventry Transplant Network participating facility, and not experimental or investigational.	10%	Not covered
TMJ Care	Includes diagnosis & treatment w/ a lifetime maximum benefit of $1,000.	10%	30%
Morbid Obesity	Charges for Medically Necessary treatment of obesity are limited to a lifetime maximum benefit of $15,000. Prior authorization required.	10%	30%
Prescription Drugs	There is a 50% coinsurance per prescription for a brand name prescription when a generic is available	Generic: $15 co-payment	
		Brand name: $15 co-payment	
Mail Order Maintenance Drugs and Medications	There is a 50% coinsurance per each order of a 3-month supply of a brand name prescription drug when a generic is available.	Generic: $15 co-payment	
		Brand name: $15 co-payment	